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Disturbed Families In Our Communities—What They Can Teach Us*

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The ordinary family in our country today seems to be subjected to increasing pressures of living. The sociologists say that some of this is the price of being an American family in a dynamic American culture. Evidences of such cultural pressures are listed as follows:

The present partial wartime mobilization is a manifestation of our culture's effort to protect its integrity, but it also adds its own impetus to the change. We recognize that one of the most important aspects of a person's health is his quality of personal adaptation to change. The emotional adaptability of an individual is perhaps the most difficult aspect of adaptability to understand and assess. One reason for this may be the fact that in our daily work we have to form relationships with those we serve, and in doing so, we ask the individual to adapt to us also. It becomes our responsibility then to understand better some of the problems we may bring to our patients, clients, and students as part of our effort to help them. Once we recognize these problems we may be able to better understand ourselves and the meaning of our services to those we serve.

It is inevitable that in meeting the demands of living the individual's personal values and his integrity comes to be tested and defined. It also is evident that with more demands placed upon individuals and families there will be more likelihood of long periods of painful anxiety and distress until a new balance in adjustment is attained. This has brought a marked increase in the seeking for support and guidance in meeting problems, and more skillful services are asked of those who offer themselves to help the family member meet his problems.

This places a difficult demand on the professional worker; he is asked to give more of himself. This is perhaps more difficult when he, too, is subjected to the same increase in pressures of living. The solving of many of the problems of mobilization or preparedness (i.e. to teach people how better to live with uncertainty) lies in solving problems we now have as professional workers, with ourselves, our clients or patients or students, our agencies, our communities. One attempt at solution is to study situations in which we have floundered and in which our patients and clients have temporarily failed to win through to greater stability.

As a person with psychiatric training, I could describe a series of individuals and point out their personality shortcomings as explanation of our failure to help them. But there is danger in this; we stop with a label and learn nothing much. It is more important to analyze the interaction between worker and patient, or client, and between members of the family. The so-called "problem family" provides us with such an opportunity. I mean by this phrase those groups of people living together who are having a particularly hard time—for a number of complicated reasons—in handling their problems of living. Here you will notice I'm not particularly concerned with how the family got this way, but more with what problems such a family poses for us as workers in the field of human relations.

For the purposes of definition, a disturbed family has many of the following symptoms: In the health records there will usually be found a high incidence

*Adapted from a talk given July 26, 1951, to the Claremont Workshop on "The Effect of Mobilization on Children and Youth," sponsored by the California Youth Authority.

of common infections among the children; chronic illness in one or several of its varied forms bedevil the family members; rheumatic fever, poliomyelitis, tuberculosis, crippling, and lameness probably have been present. In the adult, either indifference to their health problems or numerous operations are encountered. As to family unity, there is history of frequent disruptions and incompleteness. Divorce, separation, and altercation without resolvement is commonplace. The family members are known to numerous caseworkers and agencies. The problems seem rarely to be solved, or if so, new ones immediately arise to take and hold the workers' energies and attention. The agency records for these families are voluminous.

Some of the obvious forces acting on these families at first seem to be inability to make money and use it wisely, inadequate housing, minority group problems, or "inadequate personality makeup." In addition, one is struck, but the fact that practically every family decision or crisis comes as a result of emotional interactions between family members, especially the adults, causing new and increasingly difficult repercussions among family members and the nurses, doctors, teachers, social workers, and others who serve them.

From the workers' point of view, the personalities of members of these families are intriguing. At the least, they are dramatic. The inadequacies, obstinacies, and dependencies are high-lighted. The courageousness, the martyrdom, the continued will to fight often win our sympathy, our admiration and, at times, our pity along with our frustration, anger, and exasperation. I want to stress these last symptoms. In short, our definition of a disturbed family usually includes the symptoms of our own emotions and feelings being definitely involved—one way or another—and characterized by our feeling uneasy or experiencing some tension when we are dealing with the family members.

An example is the "V" family, one of a number of such families studied over the past three years by a group of community workers in a California community. This family consists of the father, almost 35 years of age, a veteran, and a salesman in a shoe store. With a history of a "nervous breakdown" and recovery before discharge from the army, he has recently moved to California. A Red Cross social worker and a Veterans Administration counselor have been helping him. Mrs. V, married after a short courtship in the early years of the last war, has borne their third child recently. It is this last birth that has brought their problem to a critical stage. On discharge from the hospital following delivery, Mrs. V didn't seem to care for the baby; subsequently feeding difficulties developed and the well-baby conference physician and the public health nurse were concerned. The baby did not do well and twice needed hospitalization seemingly because it simply wasn't getting enough food and attention. This brought the hospital social worker into the picture with whom Mrs. V formed a trustful professional relationship. To the social worker and to one of the nurses she was able to say that she really didn't want this last baby and wanted to give it for adoption. This threw Mr. V into an anxiety state, and he promptly went to his Red Cross worker and Veterans Administration counselor and related what a terrible person his wife was, as well as the hospital social worker and the nurse who seemed to him to abet her in her attitudes.

Meanwhile the other two children were showing the impact of events. The 12-year-old daughter was failing in school. Never too secure in her school academic and social accomplishments, she had nevertheless gotten by until just after the last promotion which robbed her of a teacher who liked and understood her and, by chance, substituted one whose interest in her was not so personal. The girl began to stay less at home and more with the gang. She became known to the juvenile police worker as a new member of one of the adolescent problem groups in the community. The girl's school failure brought in the school principal who asked for a parent interview. Meanwhile, the four-year-old boy, who had difficulty in accepting the start of school, began to exhibit aggressive behavior which resulted in his being requested to remain at home. This brought in another teacher, another principal, and an attendance officer into the picture who requested interviews and family history.

By this time the husband refused to allow another agency worker inside the house. The Red Cross social worker, with whom he felt secure, told him her agency couldn't continue to see him since his problem was one beyond what her agency was set up to do. He then sought and obtained relief from severe headaches and dizziness from a chiropractor who, he said, was giving him help also about his wife's problems.

Mrs. V suddenly departed, leaving home and children, for what turned out to be a period of one week. But this brought in the juvenile police worker on the question of abandonment and introduced consideration of the necessity of foster home placement.

I stop here, for I think the V family highlights for our purpose many of the problems which such a situation brings us. You may say these are the unusual, and perhaps they are, but I don't think so. The severity is but a greater degree of the same problems presented us in the "more usual" instances.

A community project with which I am associated is in progress in the City of Alameda. We spent the whole first year of the project studying 10 such

families, one each at a monthly meeting of professional workers—principals of schools, police assigned to work with juveniles, public health nurses, social workers, etc. Agency workers presented their own contributions in working with these families and discussed their roles and their agencies' philosophy of service as part of the venture.

As a result of these studies, the following facts became clearer:

1. Agency workers didn't know each other at first.
2. Agency workers in a community are professionally isolated from each other.
3. Instances occurred over a period of years offering service to a family, often with little or no knowledge of what had been accomplished by others working with the same family.
4. Agencies were often limited by policy and philosophy which interfered with the further development of therapeutic relationships—and were frankly jealous and insecure with each other.
5. Communications among some agency workers were haphazard or nonexistent. In many situations where there was informal exchange of information, it was more for the purpose of expediency than for the promulgation of a long-time plan.
6. Families became resistant and indifferent to almost all community workers after a period of frustrating therapeutic (i.e. professional) relationships with workers.
7. When a supportive relationship of family, made with a community worker, ended, the removal of such support often resulted in symptoms which needed a specialist to evaluate. In other words, failure of community worker agency relationships increased the demand for expert psychological help.

Several principles evolved from the study of these families. They were:

1. When a family became disturbed and sick, it was often the child who showed this disturbance earliest. Sometimes the manifestation occurred in the youngest, least biologically organized, member of the family—the infant or baby—who would appear at a well-baby clinic with complaint of poor sleep, poor eating, toilet training problems, etc. Perhaps six months or a year later the school child would develop symptoms to a point where he would demand attention from the school. Usually it was failure in his school work, inability to join in group activities, or aggressive behavior which called him to the attention of this agency. The adolescent would in turn be picked up for so-called pre-delinquent behavior or "in danger of becoming a delinquent" and finally, after another space of time, the police department very often got the complaint of desertion or disturbance of the peace around the adult members of the family. The agency called upon to serve the particular needs of these individuals usually didn't see its particular problem as part of this panorama of successive cries for help from the various family members. The agency often did its job very efficiently with the individual under surveillance, but the agency would rarely relate the immediate problem to that of the total family and attack it from this whole general viewpoint.
2. It became apparent that certain members of the family being given service formed rather strong therapeutic relationships with one or two community workers. The individuals in the family were given stability by these relationships, but the advent of other community workers into the family would often weaken or even destroy these primary relationships. It began to appear that certain workers have primary relationships with certain members of the family and other workers have secondary relationships. These secondary relationships were significant; but in a supportive way they were not as therapeutically important as the primary relationships. When workers recognized they had certain secondary roles, they became quite willing to act in ways supportive to the workers who had primary roles.

At the end of the first year of study of these families, the case conference group seemed to arrive at two very definite concepts of the first steps to be taken in a mental health program for Alameda. One of these concepts was that the development of a guidance service within the Alameda public schools should be encouraged, and, the other was that a system of interagency communication about certain families being serviced within the community would have to be developed. The result of the discussion was some preliminary plans for a community social service index available to all agencies participating in the case conference.

In the second year the group decided to study 10 families that had current, complicated problems. The members wished to see if they could apply what they had learned in the first year to on-going situations. During the study of families in the second year, another concept began to develop which might be called a true "preventive" principle. Often one child in the family was brought to the attention of an agency by his behavior or symptoms and study of younger children in the family often revealed that they were about to go through some of the difficulties that the older

child faced. The case conference group began to recognize that it had an obligation to provide certain needs and supports to the younger children in the family in an effort to prevent these children from developing problem situations with the agency workers and themselves that were identical with those of the older children in the family. It is my belief that this important aspect of the study should be enlarged for it is at this point, perhaps, that our studies could be most profitable. If we can learn from the problems of the older children in a family how to prevent the same problems from developing in the younger children then we really are entitled to call our work preventive.

Some of the outcomes of this type of project have been briefly summarized by some of the members of the Alameda group * as follows:

1. All professional workers have become better acquainted with each other.
2. A more definite procedure for common work among the professional workers has been established.
3. New resources have been made available for solving difficult problems.
4. A common program in community mental health has been given direction.

Studies such as these have verified our belief that new ways of consultation need to be provided for professional workers in human relations. Helping these important people—i.e., important to their students, patients, and clients—helps many more people than psychiatric personnel could or ever would see individually.

Significant experiments in providing such services are taking place in Contra Costa County, Alameda City, and San Joaquin County where community workers have joined together in projects to use the services of a teacher-psychiatrist in new ways. In the Cities of Berkeley, San Francisco, Long Beach, and of Oakland and in the County of Los Angeles psychiatrists attached to health departments work with community agency staffs on case work principles. In Napa County a psychiatric social worker is developing a similar program.

In addition, we have encouraged the application of institute or workshop method to community agencies and finally, to some extent, the community itself. Such experiences were had with several local health departments of California, the Los Angeles city school system, the Santa Barbara city school department, and with the community agencies in the City of Alameda. All were different experiments, but similar principles were used and each experiment contributed much to our thinking in this kind of education.

We have begun to introduce these principles to the physician in private practice. In 1951 Stanford University Medical School and the State Department of Public Health completed a 10-day institute for pediatricians and general practitioners on problems of medical practice around the emotions of growth and development of children. A similar institute was held in 1952 by the Children's Hospital of Los Angeles.

I would like to describe another way in which our patients, clients, and students teach us. The staff of the Mental Health Service in the State Department of Public Health constantly seeks to find new ways to give the professional worker an emotional and not merely intellectual (i.e., a content) learning experience. We have found that one of the most effective ways is to invite the worker to talk about his own problems and feelings arising from the administration of the agency with which he is identified. Over the past two to three years we have had experiences with the total working personnel of local health departments, local welfare departments, units of our State Department of Public Health, and recently the San Francisco area office staff of the State Department of Social Welfare. Those attending the meetings included the mail clerks, telephone operators, secretaries, professional workers of all categories and status, and the administrative heads of the unit.

In the local community agency groups, we talk of the patient or client and what happens to him in his contact with the agency—and what that does to us. In the state agencies we talk about the effect of our impact and requests on the local departments and what this ultimately means to the person in the community requesting help from the local agency. There are no lectures at these meetings; we discuss for two consecutive days. Essentially what we talk about is communication between people. What is the nature of it? What is the balance in the agency between mechanistic, impersonal, administrative directives, and the more personal, human, face-to-face discussion about and participation in making administrative decisions? Does the staff know each other as people, what they (as individuals) do in their work, and how they think and feel about it? Or do they know each other only as another person who keeps himself and his family fed and clothed by working and drawing an agency paycheck and as one who experiences the same job frustrations? There are other contrasts, but the importance is in this principle. The normal, conscientious worker identifies himself with his agency, its methods, and its leaders. The ideals and philosophies of an agency are always expressed in its administrative methods and

* See "A Health Department Stimulates Community Thinking for Mental Health," David Frost, M.D., M.P.H., and Genevieve Anderson, R.N., M.P.H.—American Journal of Public Health, August, 1950.

procedures. There is a strong emotional pressure, therefore, to have the staff act and feel like the administrator and supervisors act and feel. For example, if the staff is subjected to a good many authoritarian directives and orders and it has little or no opportunity to understand the reasons for these orders (or to contribute to the production of these directives), it is easy to see why a nurse, social worker, or teacher will more and more tell her patients or pupils how to live and act, and if the patients or pupils don't obey (or show appreciation of this), the worker may become angry. In such an agency there will be a tendency for workers to order their clients' and patients' lives by raw force of authority while giving lip service to mental hygiene principles. It is a healthy thing that neither the "consumer" nor the professional worker likes this, because in the long run such a relationship belittles both. Each senses that the dignity and integrity of himself depends on the other. The humiliator in turn becomes humiliated, and by his own hand. It is this deep principle in human relations which makes people willing to come together, to discuss their methods of working with each other, and to develop understanding of their natural defenses. When one's own feelings are recognized, faced, and decisions made around these feelings, one is more free to help his neighbor in a way acceptable to both.

By experience our staff is beginning to identify certain criteria, or earmarks, which inform us of the balance of pressures in an agency. Some of these are:

1. Which of the two systems of communication always present in an agency is used more—the formal, memorandum, directive, administrative channel, or the informal "grapevine"?
2. Are there more "people-minded" than "paper-minded" people in the agency?
3. In services or teaching, whose needs usually get met first—those of the agency or those of the people for whose needs the agency was established?
4. Does the clerical and secretarial staff feel apart from or identified with the professional staff?
5. What is the nature of the staff meetings of the agency? Are they mostly of the "listening" type or is there full discussion on policy?

It is our contention that significant learning comes from taking the time to develop methods whereby people can stop and take a look at themselves and what they do to, for, and with other people as part of their job. The workers then understand better what they do, and either accept their work as it is or make changes based on reason and understanding. In this process they gain further freedom to accept their students and patients and clients as they are, and thus both grow in personal stature. When a staff does not have this privilege it often develops that the staff relate to each other by complaint and disparagement and gain what comfort they can from each other in that way.

I hope I have illustrated our peculiar indebtedness as professional workers to those we serve and to our colleagues with whom we work. In addition to our own personal experiences as members of families, these people provide us with another great opportunity for learning about ourselves. It is up to us to find how this can be done more satisfyingly and efficiently.

NOTICE OF HEARING

The State Board of Public Health will hold a hearing on November 14, 1952, at 10 a.m., in Room 709, State Office Building, 217 West First Street, Los Angeles, California, on proposed promulgation of regulations to be included in the California Administrative Code, Title 17, Chapter 2, Subchapter 1, Group 1, Article 10, Section 1003, pursuant to the authority of the Health and Safety Code, Section 1603.

The proposed regulations cover exceptions to the rules relating to the preparation and distribution of human blood to become effective only when a state of extreme emergency exists as defined in Sections 1505 and 1505.5 of the California Disaster Act.

Copies of the proposed regulations are available for inspection in the California State Department of Public Health, Los Angeles and San Francisco offices. Said proposed regulations are made a part of this notice by reference.

WILTON L. HALVERSON, M.D.
Executive Officer
State Board of Public Health

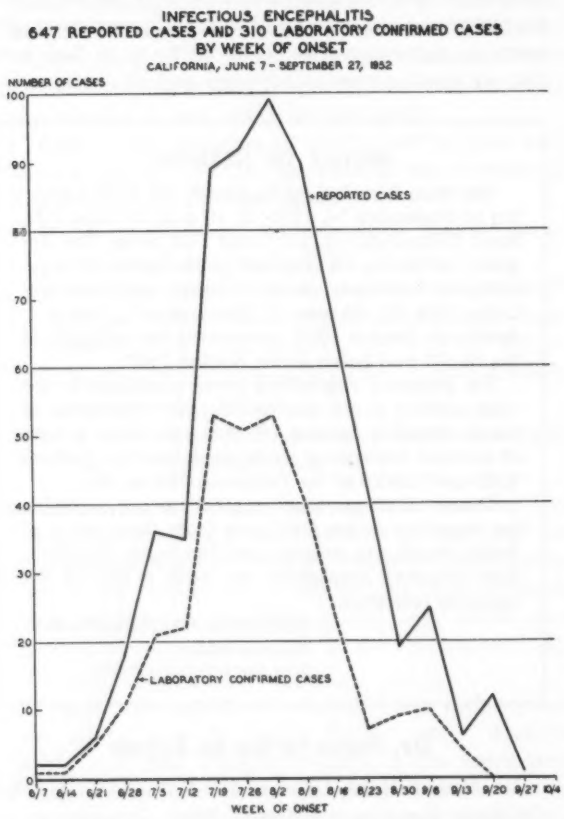
Dr. Hays to Go to Japan

Dr. Marcia Hays, Chief of the Bureau of Crippled Children Services, California State Department of Public Health, leaves for Japan on November 8 and will return December 15th. Dr. Hays is going to Japan under the auspices of the World Health Organization upon the request of the Japanese government as a short-term consultant on problems associated with their crippled children program.

Dr. Hays will assist in the development of a rehabilitation program for crippled children, including care of poliomyelitis victims; in a survey of the needs and available facilities; in the formulation of equipment and supply lists; in the selection of fellowship candidates for orthopedic nurse, physical therapist, and orthopedic surgeon to be sent to the United States for training; and in the organization of local training for personnel needed for the program.

Encephalitis Outbreak Seems Ended in Central Valley

California's 1952 outbreak of encephalitis in the Central Valley has apparently ended. Of some 49 cases reported to the State Health Department since October 1st, none has had onset of illness later than September 30th, and the last death believed due to encephalitis occurred October 8th.



During the past season 729 cases of encephalitis were reported, with 49 deaths. This is the highest incidence of the disease on record. Focus of the outbreak was in the 20 Central Valley counties, where an intensive emergency mosquito program against the *Culex tarsalis* species, principal vector of the encephalitis virus, was launched August 1st with the aid of $250,000 in emergency state funds. Emergency measures were prompted by an unprecedented mosquito population in the valley and an increasing number of encephalitis cases.

Mosquito abatement districts, serving half of the area of the Central Valley and three-fourths of its population, put forth a maximum effort, and technical aid from the State Health Department and the U. S. Public Health Service assisted local health departments in combating the *Culex tarsalis* mosquito in areas outside abatement districts.

Two types of mosquito-borne encephalitis, Western Equine and St. Louis, are known to exist in California —with cases occurring during the mosquito season. This year, the normal trend for St. Louis cases did not develop. Normally, Western Equine cases appear early in the season, leveling off in August, as happened this year, while cases due to the St. Louis virus appear in August, building up to a peak in September. However, to date only 20 cases due to the St. Louis virus are listed among laboratory confirmations by the Department Virus Laboratory.

Charted by date of onset of illness, the outbreak reached its peak in the week ending August 2d, with 98 cases recorded that week. Department records show that by the middle of September this number had dropped to less than 20 cases per week.

U. C. Opens Biochemistry and Virus Laboratory

Some of the Nation's leading scientists gathered in Berkeley for the three-day opening ceremonies, October 9-11, of the new biochemistry and virus laboratory on the Berkeley campus of the University of California.

The ultra-modern laboratory, staffed by a team of eminent scientists led by Dr. Wendell M. Stanley, Director and Nobel Laureate, is one of the world's best equipped laboratories for investigating some of man's most serious biological problems.

Prominent visiting scientists were welcomed to the laboratory at the start of the ceremonies, and joined in the opening of the Emil Fischer Library, dedicated to the "father of modern biochemistry."

On the second day the scientists participated in a symposium on viral diseases of plants and animals. At this meeting an important advance in poliomyelitis research was announced by Dr. Herald Cox, Director of virus research at the Lederle Laboratories, Pearl River, New York. This announcement has attracted world-wide attention. Dr. Cox presented a report on the production of an attenuated Lansing MEF-1 strain of poliomyelitis virus for oral use in immunization against the disease.

The imunizing power of the chick-embryo produced vaccine has not yet been tested on humans, but a similar vaccine produced from brain tissue at the Lederle Laboratories by Dr. Hilary Koprovski was used in a carefully controlled clinical test this summer by Dr. Koprovski and Dr. Karl F. Myer, director of the Hooper Foundation at the U. C. Medical Center, San Francisco. They reported that 61 children at the

Sonoma State Home had been given the vaccine in glasses of milk. Thirty days later blood tests of each child showed demonstrable amounts of polio antibodies present.

Among the other participants of the symposium were Dr. Thomas Rivers, polio expert and director of the hospital of the Rockefeller Institute for Medical Research and Dr. Vincent du Vigneaud of Cornell University, who reported the isolation of vasopressin and oxytocin, two pituitary gland hormones. A paper by Dr. Malcolm H. Merrill, Chief of the Division of Laboratories of the California State Department of Public Health, was read in his absence by Dr. Edwin Lennette, Chief Virologist of the Department's Viral and Rickettsial Disease Laboratory. The paper dealt with the importance of viral diseases in public health, the need for additional research in this field, and for improvement of diagnostic methods.

At a banquet that evening President Robert G. Sproul presided and Governor Earl Warren extended greetings. Featured speakers were Sir MacFarlane Burnet, of Australia, a world leader in virus research; Dr. Alan Waterman, Director of the U. S. National Science Foundation; and Dr. Detlev W. Bronk, President of the National Academy of Sciences.

The Pacific Slope Biochemical Conference on October 11 completed the integrated program.

Conference of Local Health Officers to Meet in Fresno

The California Conference of Local Health Officers will have its next semiannual meeting in the new health center at Fresno on November 19th through November 21st. The officers for the coming year will be elected at that time.

The present conference officers are: President—Dr. Elmer M. Bingham, San Joaquin District Health Officer, Vice-president—Dr. Roy O. Gilbert, Los Angeles County Health Officer; and Secretary—Dr. James C. Malcolm, Alameda County Health Officer.

Public Health Nursing Vacancies

Yolo County: A public health nursing position is open in the Yolo County Health Department. The salary is $323 per month plus $60 flat rate for car allowance. For additional information contact Dr. Herbert Bauer, Health Officer, Yolo County Health Department, Woodland, California.

City of Long Beach: A noncompetitive examination will be given for the position of public health nurse in the Long Beach City Health Department on November 25, 1952. Applications must be filed by November 17, 1952. Salary range is $303 to $367. Candidates must possess a California Public Health Nursing Certificate and establish residence in the City of Long Beach at the time of appointment. Inquiries should be directed to the Long Beach Civil Service Board, 332 Municipal Utilities Building, Long Beach, California.

Infectious Hepatitis Being Studied In Institution Outbreaks

At the request of the State Department of Mental Hygiene and in close cooperation with the medical staffs of Sonoma State Home and of Pacific Colony, the State Health Department's Bureau of Acute Communicable Diseases is conducting investigations of the current outbreaks of infectious hepatitis in these two state institution. At Sonoma, following discussions with the staff of the institution, the State Health Department assigned Dr. Ernest Kane to make a thorough epidemiologic investigation of the occurrence of hepatitis at this institution. The cases had begun to appear in numbers in August following sporadic cases in April and June. Cases have now occurred in 17 of the 31 cottages and up to October 9th some 80 cases have been recognized (17 in August, 48 in September, 13 in October).

In 1949, an intensive study of an outbreak of infectious hepatitis at Sonoma was carried out by the State Health Department and the University of California. During this first outbreak of some 260 cases, gamma globulin was used extensively in an attempt to observe and evaluate its effectiveness in control of the epidemic in an institution. It is particularly fortunate to have this opportunity to observe and study a second outbreak in a population group for which considerable study material is already available.

Prophylactic use of gamma globulin has been instituted with the cooperation of the American Red Cross which has generously released the necessary quantities of gamma globulin for study purposes at both Sonoma State Home and Pacific Colony.

The cases at Pacific Colony have been occurring sporadically since April, but increasing in numbers during the latter part of August and the first week of September. The incidence up to October 7th is 48 cases. At Pacific Colony, the Los Angeles County Health Department is carrying the responsibility for the investigation and epidemiologic follow-up, and the State Health Department is supervising the use of the American Red Cross gamma globulin, so that the results obtained at Pacific Colony and at Sonoma will be comparable and that perhaps new information concerning the mode of transmission of infectious hepatitis and effective methods for its control might be determined from these two interesting episodes.

A new low dosage of gamma globulin is being utilized. This dosage has been reported by Dr. Joseph Stokes, Jr., to be effective in institutional outbreaks. Dr. Stokes, who is professor of pediatrics at the University of Pennsylvania, is a leading authority in this field.

The plan calls for immunization of all individuals in the infected wards and of all attendants and others working in or having contacts with the infected wards. An "immune barrier" is thus being set up between the infected wards and the "clean" cottages in an attempt to limit the spread of the hepatitis virus in the institutions concerned.

The immunizations with gamma globulin have been completed at Sonoma and are currently under way at Pacific Colony. Close liaison between the Department of Public Health and the Department of Mental Hygiene is being maintained and, at the conclusion of the study, joint publications of the information obtained will result.

City, County Hospital Laboratories Must Have State Permit

City and county hospitals which operate clinical laboratories are included in the provisions of the Clinical Laboratory Act and must obtain permits from the State Department of Public Health. This is the opinion of the Attorney General, issued October 2d at the request of the department for clarification of this point. The act, adopted by the 1951 Legislature and incorporated into the Business and Professions Code (Sections 1200-1322), provides for the general supervision of the clinical laboratories within the State.

The Attorney General's opinion states that "there is little doubt as to the intent of the Legislature with respect to the inclusion of a city, county, or city and county within its provisions." Subdivisions (e) and (f) of Section 1300 of the Business and Professions Code provide that when the applicant is a city, county or city and county, or official thereof, no application fee or annual renewal fee shall be required. "Thus by necessary implication it is most apparent that the Legislature contemplated applications to the State Department of Public Health by city, county, or city and county clinical laboratories."

Clinical laboratories operated by the State or by any department or agency of the U. S. Government are not included under provisions of the act. The opinion makes it clear that clinical laboratories operated by city and county institutions are not to be considered as state agencies.

Review of Reported Communicable Disease Morbidity—September, 1952

Diseases	*Sept. 1952*	*Sept. 1951*	*Sept. 1950*	*5-Year Median*
Diseases With Incidence Exceeding the Five-year Median				
Amebiasis	43	29	31	23
Encephalitis	151	31	55	35
Food poisoning	73	48	13	39
German measles	141	110	116	119
Hepatitis, infectious	104	27	22	13
Malaria	28	3	3	3
Measles	265	258	264	258
Meningitis, meningococcal	21	14	12	14
Mumps	851	435	509	509
Pertussis	410	250	362	302
Poliomyelitis	730	581	331	518
Shigella infections	85	46	44	46
Typhoid fever	17	9	8	14
Diseases Below the Five-year Median				
Diphtheria	4	11	11	26
Rabies, animal	4	2	5	7
Tetanus	3	6	9	9
Tuberculosis and the Venereal Diseases				
Venereal diseases				
Syphilis	623	589	725	839
Gonococcal infections	1,238	1,327	1,466	1,614
Chancroid	13	28	26	[1]
Granuloma inguinale	1	4	1	[1]
Lymphogranuloma venereum	2	5	22	[1]
Tuberculosis (all forms)	520	545	638	[1]

[1] Median not calculated.

San Diego Openings

San Diego Health Department announces openings for two public health physicians and for one public health analyst. Interested applicants should contact the San Diego County Department of Civil Service and Personnel, Room 402, Civic Center, San Diego, California.

Physician I and II. Salary range for Physician I is $587-$647; for Physician II, $679-$749. Applicants must possess a valid license to practice medicine in the State of California before appointment. Physician II position requires at least two years experience, one of which must be professional medical experience in a public health department or a M.P.H. degree from an approved School of Public Health. Information concerning additional experience requirements may be obtained from the Department of Civil Service and Personnel. There are no experience requirements for Physician I.

Public Health Analyst. Salary range: $327 to $397. Applicants must have had one year of experience as a public health analyst or statistician in a department of public health, or comparable position.

New Health Bulletin

Health Highlights, published by the Riverside County Health Department, is the newest of the periodical bulletins issued by California health departments to inform their communities of local public health problems and programs. The first issue came out in May, 1952.

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